

9695

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Dorchester</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>13</u> OR <u>Cambridge</u>	LENGTH OF STAY (in this place) <u>life</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>13</u> OR <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Maryland Hospital</u>		STREET ADDRESS (If rural give location) <u>Hughlett</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Nancy Ellen Willey Abbott</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>10</u> <u>12</u> <u>19 55</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>April 25, 1885</u>
9. AGE last birthday <u>70</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>seamstress</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Shirt Factory</u>	
11. BIRTHPLACE (State or foreign country): <u>Lakesville, Maryland.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Henry Willey</u>		14. MOTHER'S MAIDEN NAME: <u>Sarah E. Wroten</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Not KNOWN</u>	
17. INFORMANT & ADDRESS: <u>Cambridge, Md.</u> <u>Mrs. Charles Whaples, Hughlett St.,</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>			<u>10 minutes</u>
ANTECEDENT CAUSE (B) <u>Arterio-sclerosis Generalized</u>			<u>5 years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Diabetes Mellitus</u>			<u>5 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hemiplegia; lt.</u>			<u>24 hrs</u>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY <u>street office bldg., etc.</u>	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-28</u> , 19 <u>55</u> , to <u>10-12</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-12</u> , 19 <u>55</u> , and that death occurred at <u>4:50 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Eldred H. Doff</u>		M. D. <u>Cambridge Md.</u> DATE SIGNED <u>10-16-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Burial</u>	DATE THEREOF: <u>10/15/55</u>	NAME OF CEMETERY OR CREMATORY: <u>Dorchester Memorial Park</u>	LOCATION (City, town, or county) (State): <u>Cambridge, Maryland.</u>
DATE REC'D BY LOCAL REGISTRAR: <u>Oct 15 1955</u>	REGISTRAR'S SIGNATURE: <u>John H. Doff</u>	24. FUNERAL DIRECTOR ADDRESS: <u>Le Compte Funeral Service, Cambridge, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

OCT 20 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9775

CERTIFICATE OF DEATH

Reg. Dist. No. 097703

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Dorchester</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Caroline</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Cambridge</i>	LENGTH OF STAY (in this place) <i>11 days</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>American Corners</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Eastern Shore State Hospital</i>		STREET ADDRESS (If rural give location) <i>05X-2</i>	

3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <i>Frederick</i>	(Middle) <i>Hermon</i>	(Last) <i>Beauchamp</i>	OF DEATH: <i>10 - 8 19 55</i>
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>5-17-1875</i>
9. AGE last birthday <i>80</i>		10. IF UNDER 1 YEAR: Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Farm Owner</i>	11. BIRTHPLACE (State or foreign country): <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		13. FATHER'S NAME: <i>William Beauchamp</i>	
14. MOTHER'S MAIDEN NAME: <i>Bess Sullivan</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>	
16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT & ADDRESS: <i>Eastern Shore State Hospital records</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
IMMEDIATE CAUSE (A) <i>420.0</i>	DUE TO <i>Arteriosclerotic Heart Disease</i>	<i>1 yr +</i>
ANTECEDENT CAUSE (B)	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	(B) <i>Generalized Arteriosclerosis</i>	<i>10 yr +</i>
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19a. DATE OF OPERATION: <i>None</i>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <i>9-27-1955</i> to <i>10-8, 1955</i> that I last saw the deceased alive on <i>10-8, 1955</i> , and that death occurred at <i>5:30 P.M.</i> from the causes and on the date stated above.	
SIGNATURE <i>George S. Currier</i>	DATE SIGNED <i>10-8-55</i>
ADDRESS <i>Cambridge, Md.</i>	

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>October 12, 1955</i>	NAME OF CEMETERY OR CREMATORY <i>Hill Crest Cemetery</i>	LOCATION (City, town, or county) (State) <i>Federalburg, Maryland</i>
DATE REC'D BY LOCAL REGISTRAR <i>Oct. 12, 1955</i>	REGISTRAR'S SIGNATURE <i>John A. ...</i>	24. FUNERAL DIRECTOR <i>J. J. Frampton</i>	ADDRESS <i>44 Box, Federalburg, Md.</i>

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

OCT 13 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9696

09704
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 116

1. PLACE OF DEATH: COUNTY <u>Dorchester</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge-Maryland Hospital</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Dorchester</u> CITY (If outside corporate limits write RURAL and give nearest town) <u>Bishops Head</u> TOWN STREET ADDRESS <u>Rural</u> (If rural, give location)			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Perry Wesley Bramble</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 31, 1955</u> 19				
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Feb. 2, 1871</u>	9. AGE last birthday: <u>84</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min. <u>84</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired Waterman self employed</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>Bishops Head</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME: <u>George D. Bramble</u>			14. MOTHER'S MAIDEN NAME: <u>Mary E. Moore</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u> <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Mrs. J. Naamon Mills, Bishops Head, Md.</u>			
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>420.1</u> Immediate cause (a) <u>Coronary Occlusion</u> DUE TO Antecedent cause(s) (b) <u>giving rise to the above cause</u> stating underlying cause last (c) <u>204.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs.</u>		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Fracture Left Femur</u>					<u>34 days</u>		
19a. DATE OF OPERATION: <u>10/1/55</u>		19b. MAJOR FINDING OF OPERATION: <u>Hip Pinning</u>			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>Home</u>		21c. (City or town) (County) (State) <u>Bishops Head Dorchester Md.</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>9/27/55 9 A. M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Fell in his home.</u> <u>29</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>J. M. Moore</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> DATE SIGNED <u>Nov. 2 '55</u>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removal</u>		DATE THEREOF <u>Nov. 2, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Robinson Family Cemetery</u>			
DATE REC'D BY LOCAL REG. <u>Nov. 1, 1955</u>		REGISTRAR'S SIGNATURE <u>J. M. Moore</u>		24. FUNERAL DIRECTOR <u>Kenneth R. Thomas, Cambridge, Md.</u>			
LOCATION (City, town, or county) (State) <u>Bishops Head, Md.</u>		ADDRESS <u>Bishops Head, Md.</u>					

1977 (14)

BUREAU V. 87

EST. 1905

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9706

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09705

Reg. Dist.

No. 110

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:							
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>					
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)							
<input checked="" type="checkbox"/> TOWN <u>Hurlock—Rural</u>		<u>10 yrs.</u>		TOWN <u>Hurlock—Rural</u>							
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hurlock, Md. R. F. D.</u>				STREET ADDRESS <u>Hurlock, Md. R. F. D.</u> (If rural, give location)							
3. NAME OF DECEASED: (First) <u>Cecil</u>		(Middle)		(Last) <u>Crawford</u>		4. DATE OF DEATH (Month) <u>October</u> (Day) <u>17</u> (Year) <u>1955</u>					
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>June 10, 1901</u>		9. AGE last birthday: <u>54</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td>IF UNDER 1 YEAR</td><td>IF UNDER 24 HRS.</td></tr><tr><td>Months <u>4</u></td><td>Days <u>7</u> Hours <u>1</u> Min.</td></tr></table>			IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months <u>4</u>	Days <u>7</u> Hours <u>1</u> Min.
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months <u>4</u>	Days <u>7</u> Hours <u>1</u> Min.										
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Canning Factory—Phillips Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Alabama</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME: <u>Daniel C Crawford</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Judie</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>217-14-8067</u>		17. INFORMANT & ADDRESS: <u>Mrs. Cecil Crawford, Hurlock, Md. R. F. D.</u>							
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH				
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							<u>5 min.</u>				
<u>420.1</u> Immediate cause (a) <u>Coronary occlusion</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)											
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.											
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County)		21d. (State)					
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?							
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .											
SIGNATURE <u>John M. [Signature]</u>		M. D. <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>10/17/55</u>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Oct. 22, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Washington Cemetery</u>		LOCATION (City, town, or county) (State) <u>Hurlock, Md.</u>					
DATE REC'D BY LOCAL REG. <u>Oct 22-1955</u>		REGISTRAR'S SIGNATURE <u>Charles Hastings</u>		24. FUNERAL DIRECTOR <u>J. J. Frampton and Son, Federalsburg, Md.</u>		ADDRESS					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with page 3 before burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

~~DUPLICATE COPY~~

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cambridge		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cambridge			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Home				d. STREET ADDRESS R.F.D. # 3		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ROLAND Middle DAIL Last DAIL				4. DATE OF DEATH Month October Day 3 Year 1955			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 7, 1889		9. AGE (In years lost birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self-Employed		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) R.F.D. Cambridge, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H. Dail				14. MOTHER'S MAIDEN NAME Mary I. Keyes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service)		17. INFORMANT Mrs. Elizabeth E. Dail Cambridge, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Adenocarcinoma 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of prostate DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 30 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/20 , 19 52 , to 10/3 , 19 55 ; that I last saw the deceased alive on 10/3 , 19 55 , and that death occurred at 4:10 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE W. H. Hanks		ADDRESS (Street, city or town, state) Cambridge, Md.				DATE SIGNED 5/19/56	
PHYSICIAN'S NAME (Type) Dr. William H. Hanks M.D. Locust Street Cambridge, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/5/55		22c. NAME OF CEMETERY OR CREMATORY Seward-Dail Cemetery		22d. LOCATION (City, town, or county) (State) R.F.D. # 3 Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE LeCompte Funeral Service				ADDRESS Cambridge, Maryland		24a. RECEIVED BY REGISTRAR DATE May 21, 1956	
				24b. REGISTRAR'S SIGNATURE John H. H. W.			

MEDICAL CERTIFICATION

MAINE STATE DEPARTMENT OF HEALTH—BALTIMORE 18

BUREAU V. S.

MAY 23 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09707

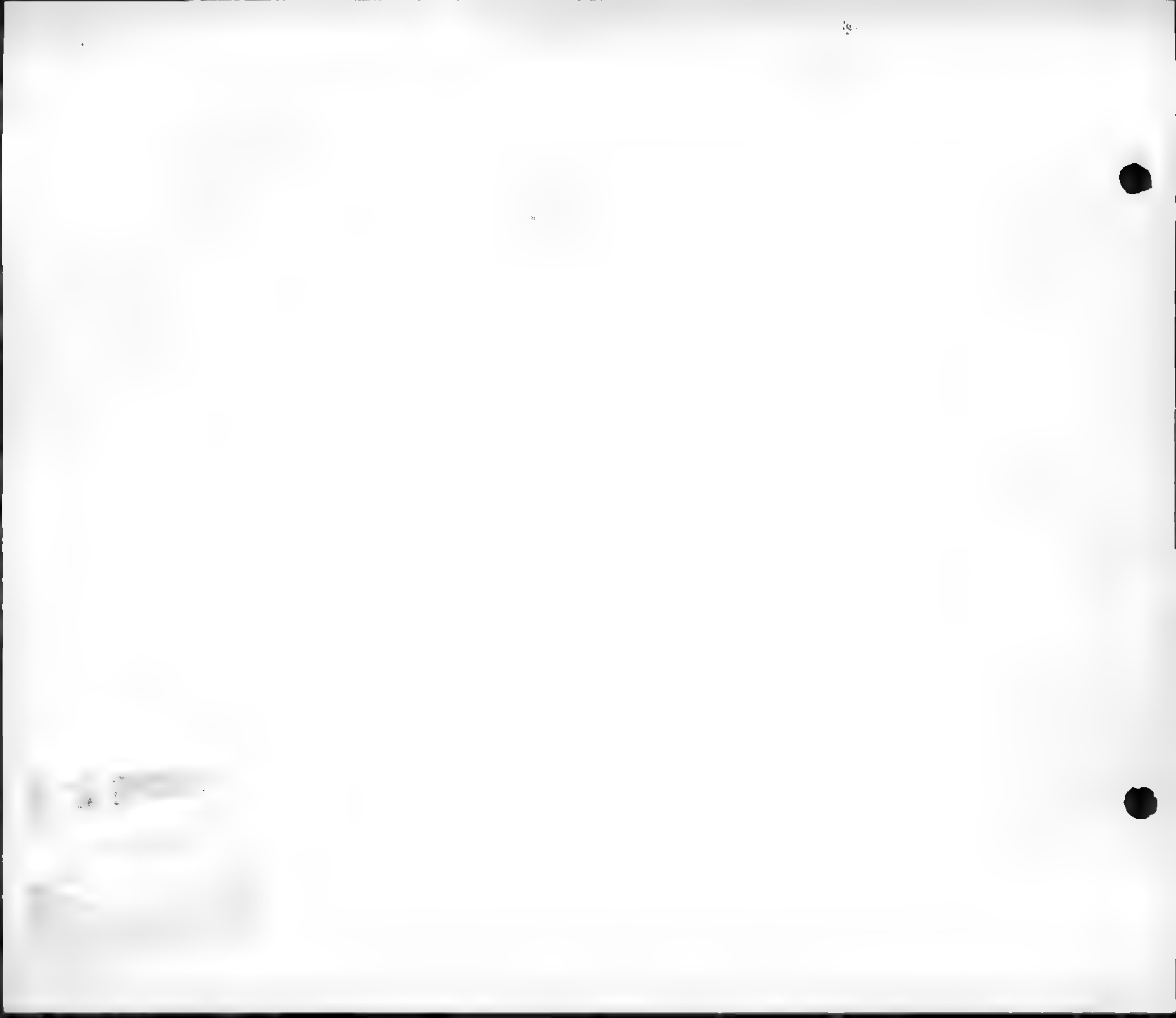
9737

CERTIFICATE OF DEATH

Reg. Dist. No.

116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED.			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>rural Cambridge</u>		<u>1 mo.</u>		OR TOWN <u>Cambridge, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>16 Eastern Shore State Hospital</u>				<u>1</u>			
3. NAME OF DECEASED: (First)		(Middle)		(Last)		4. DATE (Month) (Day) (Year)	
DECEASED: (Type or Print) <u>WADE</u>		<u>HAMPTON</u>		<u>FALLIN</u>		OF DEATH <u>Oct. 11</u> <u>1955</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify):	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>male</u>	<u>white</u>	<u>single</u>	<u>2/21/31</u>	<u>74 yrs</u>	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>watchman</u>						<u>Md.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Christopher Fallin</u>				<u>Augie Edgar</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>no</u>				<u>no</u>		<u>Eastern Shore State Hospital records</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>450.0</u>							
IMMEDIATE CAUSE (A) <u>General arteriosclerosis</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Psychosis with Cerebral arteriosclerosis</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Sept. 8, 1955 to Oct. 11, 1955 that I last saw the deceased alive on Oct. 11, 1955, and that death occurred at 9:37aM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
<u>Thomas J. Drayton</u>				<u>M. D. U.S.S.H., Cambridge, Md.</u>		<u>10/11/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/11/55</u>		<u>Harrogate</u>		<u>Harrogate Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR'S ADDRESS			
<u>Oct. 13, 1955</u>		<u>John H. Hall</u>		<u>Le Compton Funeral Home</u>			
				<u>Cambridge, Md.</u>			



MARGIN RESERVE FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

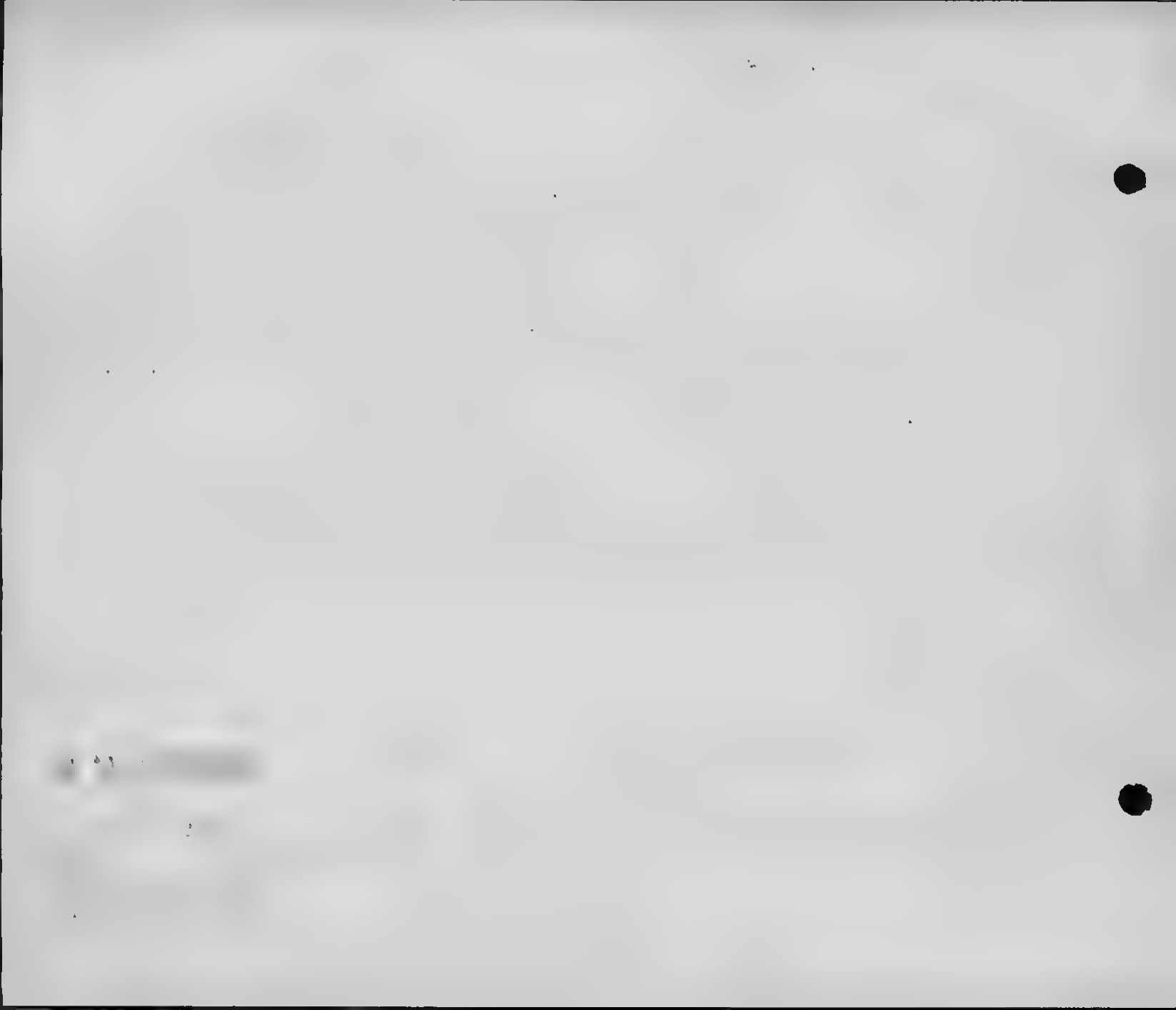
9738

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

99708
Reg. Dist.

No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Somerset</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Cambridge</u>		<u>29yrs. 9mo. 7days</u>		TOWN <u>-</u>		<u>19x-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>				STREET ADDRESS (If rural, give location) <u>-</u>			
3. NAME OF DECEASED:		(First)		(Middle)		(Last)	
(Type or Print) <u>Erna</u>		<u>-</u>		<u>Gibbons</u>			
4. DATE OF DEATH		(Month)		(Day)		(Year)	
<u>Oct.</u>		<u>1</u>		<u>1955</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>F</u>		<u>White</u>		<u>Single</u>		<u>Jan. 13, 1886</u>	
9. AGE last birthday:		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<u>69</u> yrs.		Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Laborer</u>		<u>-</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>William J. Gibbons</u>				<u>Martha Daughterty</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>no</u>		<u>-</u>		<u>Eastern Shore State Hospital Records</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Septicemia</u>						<u>3 days</u>	
DUE TO							
Antecedent cause(s) (b) ..							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
<u>-</u>				<u>-</u>			
20. AUTOPSY?							
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town) (County) (State)			
<u>-</u>		<u>-</u>		<u>-</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>-</u>		<u>-</u>		<u>-</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>John M. D.</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>10/4/55</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>10/6/55</u>		<u>Eastern Shore State Hospital</u>		<u>Cambridge, Md.</u>	
DATE REC'D BY LOCAL REG		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Oct. 6, 1955</u>		<u>John M. D.</u>		<u>Lecompte Funeral Service</u>		<u>Cambridge, Md.</u>	



9709

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Dorchester</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge R.F.D.1</u>	LENGTH OF STAY (In this place) <u>46 years</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge R.F.D.1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D.1</u>		STREET ADDRESS <u>R.F.D.1</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>William</u>	(Middle) <u>Frederick</u>	(Last) <u>Hoge</u>	DATE OF DEATH: <u>Oct. 6, 1955</u> 19
5. SEX. <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>April 19, 1876</u>
9. AGE last birthday: <u>79</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country): <u>Lake Minnisoto, Minn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>William F. Hoge</u>		14. MOTHER'S MAIDEN NAME: <u>Eliza Fischer</u>	
15. WAS DECEASED EVER IN U.S. ARMY OR FORCEST (Yes, no, or unk.) (If Yes, give war or dates of service): <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Marcia J. Hoge, R.F.D.1 Cambridge, Md.</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cirrhosis of the liver</u>		<u>6 mos.</u>	
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerosis</u>		<u>8 yrs</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>10/3</u> , 19 <u>55</u> , to <u>10/4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/3</u> , 19 <u>55</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above.		DATE SIGNED <u>10/12/55</u>	
SIGNATURE <u>Edna B. Bunker</u>		ADDRESS <u>9 Rose St., Cambridge, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Oct. 6, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct. 6, 1955</u>		REGISTRAR'S SIGNATURE <u>Frederick Hoge, Jr.</u>	
24. FUNERAL DIRECTOR <u>Kenneth R. Thomas, Cambridge, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

96977
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09710
 Reg. Dist. No. 126

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Dorchester</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cambridge</u>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>29 Park Lane</u>		STREET ADDRESS (If rural, give location) <u>29 Park Lane</u>	
3. NAME OF DECEASED: (Type or Print)	(First)	(Middle)	(Last)
<u>E. A.</u>	<u>JOHN</u>	<u>HOOVER</u>	
4. DATE OF DEATH	(Month)	(Day)	(Year)
<u>Oct.</u>	<u>4</u>	<u>19</u>	<u>55</u>
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Female</u>	<u>Colored</u>	<u>Widowed</u>	<u>June 15, 1888</u>
9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>67</u> yrs.	Months	Days	Hours
<u>57</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
<u>Housewife</u>		<u>Maryland</u>	<u>USA</u>
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>George Travers</u>		<u>Lizzie Travers</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
		<u>none</u>	<u>Outie Cornish: Cambridge, Md.</u>
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			<u>Instant</u>
Immediate cause (a) <u>Coronary Occlusion</u>			
DUE TO			
Antecedent cause(s) (b) _____			
Diseases or conditions, if any, giving rise to the above cause DUE TO			
stating underlying cause last (c) _____			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
19a. DATE OF OPERATION:			20. AUTOPSY?
19b. MAJOR FINDING OF OPERATION:			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town)	(County)
			(State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>John M. ...</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>10-11-55</u>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>buried</u>	<u>Oct. 7, 1955</u>	<u>Burial with Cemetery</u>	<u>Dorchester Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Oct 7 1955</u>	<u>John M. ...</u>	<u>Herbert M. Stclair</u>	<u>Cambridge, Md.</u>



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9538

09712

Reg. Dist. No. 216

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u> Md. </u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4 Slocum Street</u>				STREET ADDRESS (If rural, give location) <u>4 Slocum Street</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Phillip</u>		(Middle) <u>Robert</u>		(Last) <u>Mack</u>	
				4. DATE OF DEATH		(Month) (Day) (Year) <u>Oct. 17, 1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>Apr. 12, 1955</u>		9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. yrs <u>5</u> Months <u>30</u> Days <u>130</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Charles Phillip Green</u>				14. MOTHER'S MAIDEN NAME: <u>Katherine Mack</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Katherine Mack Cambridge, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>57.2</u> Immediate cause (a) <u>Toxemia</u> DUE TO Antecedent cause(s) (b) <u>Acute Respiratory Infection</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>[Signature]</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Oct. 18, 1955</u> M. D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct. 19, 1955</u>		<u>Old Field</u>		<u>Dorchester Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Oct. 18, 1955</u>		<u>[Signature]</u>		<u>Hartest St. 07 in Cambridge, Maryland</u>			

4045274211

EDWARD V. S.

100

100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9710

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09713

Reg. Dist.

No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Elliotts</u>				TOWN <u>Elliotts #2</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Fishing Bay</u>				STREET ADDRESS (If rural, give location) <u>/</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Type or Print <u>Ira</u> <u>Fulton</u> <u>McCreedy</u>				DATE OF DEATH <u>Oct.</u> <u>28</u> <u>19</u> <u>55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>May 25, 1925</u>	9. AGE last birthday: <u>72</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Waterman</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>Own Boat</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME: <u>Wise McCreedy</u>				14. MOTHER'S MAIDEN NAME: <u>Alice Dayton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mrs. Sarah McCreedy, Elliotts, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						Instant	
<u>475X</u> Immediate cause (a) <u>Drowning</u> DUE TO Antecedent cause(s) (b) <u></u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u></u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>Ell: ++</u>		21c. (City or town) (County) (State): <u>Ell: ++</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>Oct. 28 1955</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Accident - slipped in fishin. bay</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>J. M. J.</u>		M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>		DATE SIGNED: <u>Oct. 30 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>buried</u>		DATE THEREOF: <u>Oct. 30 1955</u>		NAME OF CEMETERY OR CREMATORY: <u>Elliotts Cemetery</u>		LOCATION (City, town, or county) (State): <u>Elliotts, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>Oct 29 1955</u>		REGISTRAR'S SIGNATURE <u>Attest: J. M. J.</u>		24. FUNERAL DIRECTOR <u>Aut. S. J. J.</u>		ADDRESS <u>Aut. S. J. J.</u>	



CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Dorchester	MARYLAND	STATE Maryland	COUNTY Dor.
CITY (If outside corporate limits, write RURAL OR and give nearest town) Cambridge	LENGTH OF STAY (in this place) 3 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Vienna, Md. R.F.D.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cambridge-Maryland Hospital		STREET ADDRESS (If rural give location) Rural	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH:	
Addie (First) Jones (Middle) Oliphant (Last)		Oct. 12, 1955 19	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: Mar. 11, 1915
9. AGE last birthday:		10. CITIZEN OF WHAT COUNTRY?	
40 yrs.		U.S.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife		10b. KIND OF BUSINESS OR INDUSTRY:	
		Church Creek, Md.	
13. FATHER'S NAME: T. Ira Jones		14. MOTHER'S MAIDEN NAME: Frances Saunders	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): (If Yes, give war or dates of service) No		16. SOCIAL SECURITY NO.:	
		17. INFORMANT & ADDRESS: T. Ira Jones, 201 Choptank Ave., Cambridge	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			Interval Between Onset And Death 5 days
082 X Immediate cause (a) Meningo encephalitis (acute)			
Antecedent causes (s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED (White at Work) (Not White At Work)	
22. I hereby certify that I attended the deceased from 10/9, 1955, to 10/12, 1955, that I last saw the deceased alive on 10/12, 1955, and that death occurred at 8:00 P. from the causes and on the date stated above.		DATE SIGNED 10/13/55	
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
DATE THEREOF Oct. 15, 1955		Dorchester Memorial Park	
DATE REC'D BY LOCAL REGISTRAR Oct. 14, 1955		REGISTRAR'S SIGNATURE John Y. Lee, M.D.	
24. FUNERAL DIRECTOR		ADDRESS	
Kenneth R. Thomas, Cambridge, Md.			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No. 116

97.0

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dor.</u>	
CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN <u>Cambridge</u>				CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN <u>Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge-Maryland Hospital</u>				STREET ADDRESS (If rural give location) <u>138 Race Street</u>			
3. NAME OF DECEASED:		(First) <u>John</u>		(Middle) <u>Wesley</u>		(Last) <u>Paul</u>	
(Type or Print)							
4. DATE OF DEATH: <u>Oct. 15, 1955</u>		19 <u>19</u>		5. SEX: <u>Male</u>		6. RACE: <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>June 1, 1868</u>		9. AGE last birthday: <u>87</u> YRS.		10. IF UNDER 1 YEAR: Months <u>12</u> Days <u>1</u>	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Carpenter retired</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Cambridge</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>John Paul</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Reese</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Mrs. Ear Johnson, 138 Race St. Cambridge, Md.</u>			
(If Yes, give war or dates of service)							
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
<u>420.0</u> Immediate cause (a) <u>Cardiac failure</u>						<u>1 day</u>	
Antecedent causes (s) (b) <u>Cardiac decompensation</u>						<u>2 wks</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Arteriosclerotic Heart Disease</u>						<u>unknown</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE HOMICIDE		OF INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/15</u> , 19 <u>55</u> , to <u>10/15</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/15</u> , 19 <u>55</u> , and that death occurred at <u>2:00 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Alfred R. Maryanor</u>		(Degree or title) <u>M.D.</u>		ADDRESS <u>136 Race St., Cambridge</u>		DATE SIGNED <u>10/17/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct. 17, 1955</u>		<u>Cambridge Cemetery</u>		<u>Cambridge, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct 17 1955</u>		REGISTRAR'S SIGNATURE <u>John Y. Lee</u>		24. FUNERAL DIRECTOR <u>Kenneth R. Thomas</u>		ADDRESS <u>Cambridge, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

OCT 10 1955

RECEIVED

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11399
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11915
Reg. Dist.

No. 776

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Talbot</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Dambridge</u>		LENGTH OF STAY (in this place) <u>3 hrs. - 15 min.</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Easton, Maryland</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hospital</u>				STREET ADDRESS (If rural, give location) <u>--</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>Stella</u>		(Middle) <u>--</u>		(Last) <u>Rash</u>		(Month) (Day) (Year) <u>Oct. 20 19 55</u>	
6. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>		8. DATE OF BIRTH: <u>Nov. 8, 1898 (?)</u>	
9. AGE last birthday: <u>57</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>--</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Charles Harris</u>				14. MOTHER'S MAIDEN NAME: <u>Emma Willis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>--</u>		16. SOCIAL SECURITY No.: <u>--</u>		17. INFORMANT & ADDRESS: <u>Eastern Shore State Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						1. day.	
Immediate cause (a)..... <u>Cerebral embolus</u> DUE TO Antecedent cause(s) (b)..... <u>Generalized arteriosclerosis</u> Diseases or conditions, if any, giving rise to the above cause, stating underlying cause last (c).....						?	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>John H. H. H.</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12/20/55</u> M. D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REG. <u>12/30/55</u>		REGISTRAR'S SIGNATURE <u>John H. H. H.</u>		24. FUNERAL DIRECTOR <u>Surice & Son</u>		ADDRESS	

9711

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH.		2. USUAL RESIDENCE (HOME) OF DECEASED.	
COUNTY <u>Dorchester</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Rural Cambridge 2 yrs 6 mos</u>		OR TOWN <u>Hub Lock</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>Eastern Shore State Hosp.</u>		<u>Main St.</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last)		OF DEATH: <u>Oct 2 1955</u>	
<u>James Bowen Richards</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>Ir</u>	
7. SINGLE MARRIED. WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>March 1897</u>	
9. AGE last birthday: <u>58</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life.)		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>Operator</u>		<u>Perma R. R.</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Harvey B. Richards</u>		<u>Hettie Disharoon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>Yes - World War I</u>			
17. INFORMANT'S ADDRESS:		18. MEDICAL CERTIFICATION	
<u>Hospital Records, Cambridge</u>		DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE		(A) <u>Cerebral Haemorrhage</u>	
ANTECEDENT CAUSE, (S)		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <u>Cerebral Arteriosclerosis</u>	
		DUE TO	
		(C)	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Mar 14, 1953</u> , to <u>Oct 2, 1955</u> , that I last saw the deceased alive on <u>Oct 1, 1955</u> , and that death occurred at <u>4:40 AM</u> , from the causes and on the date stated above.			
SIGNATURE		ADDRESS	
<u>James J. W. Judge</u>		<u>M.D. Cambridge Md</u>	
DATE SIGNED			
<u>Oct 2 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>10/5/55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Washington</u>		<u>Hub Lock, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>Oct 5 1955</u>		<u>J. L. Vance M.D.</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Ruth S. Hellingby</u>		<u>East New Market, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

3. 1. 1950

1

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be examined within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9701

CERTIFICATE OF DEATH

09717

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Dorchester		MARYLAND		STATE Maryland		COUNTY Dorchester	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Cambridge		2 weeks		TOWN Cambridge			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cambridge-Maryland Hospital				STREET ADDRESS 112 Locust Street			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Edward Allen Robbins				4. DATE OF DEATH (Month) (Day) (Year) Oct. 27, 1955			
5 SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Oct 12, 1898	9 AGE last birthday 57 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS
					Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager County Liquor Stores			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cambridge		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME William E. Robbins				14. MOTHER'S MAIDEN NAME Helen Henry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY NO. U.S.M.C. 1917-1937 219-20-7039		17. INFORMANT & ADDRESS 112 Locust St., Mrs. Elizabeth R. Robbins, Cambridge, Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) Uremia						10 days	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) Coronary thrombosis, acute ant						14 days	
(C) Pulmonary infarction						10 days	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct 12 , 19 55 , to Oct 27 , 19 55 , that I last saw the deceased alive on Oct 27 , 19 55 , and that death occurred at 8:30 P. from the causes and on the date stated above.							
SIGNATURE W. W. Thompson M.D.				DATE SIGNED Oct 28, 55			
23 BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Oct. 29, 1955		NAME OF CEMETERY OR CREMATORY Christ Church Cemetery		LOCATION (City, town, or county) (State) Cambridge, Md.	
24 REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE John H. D.		25 FUNERAL DIRECTOR'S SIGNATURE Kenneth R. Thomas		ADDRESS Cambridge, Md.	
DATE Oct. 24, 1955							

James K. Hume

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS ARC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09718

9712

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Woolford</u>		<u>10yrs</u>		TOWN <u>Woolford</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>none</u>				<u>none</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Carrie</u> (Middle) <u>Harrington</u> (Last) <u>Robinson</u>				(Month) <u>10</u> (Day) <u>21</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS
<u>f</u>	<u>W</u>	<u>Widow</u>	<u>Nov. 11, 1867</u>	<u>87</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Home</u>		<u>Madison, Md</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Samuel P Harrington</u>				<u>not known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>(If Yes, give war or dates of service)</u>		<u>none</u>		<u>Mrs Claude Brooks Woolford Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
3 <u>3</u> X IMMEDIATE CAUSE (A)				<u>Cerebral Hemorrhage</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Arteriosclerosis, generalized</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)							
DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>4 days</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/17</u> , 19 <u>55</u> , to <u>10/20</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/20</u> , 19 <u>55</u> , and that death occurred at <u>7:55</u> A.M. from the causes and on the date stated above							
SIGNATURE				DATE SIGNED			
<u>Lawrence Manganov</u> M.D.				<u>Cambridge Md</u> <u>10/22/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/23/55</u>		<u>Old Trinity</u>		<u>Dorchester Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Oct. 23, 1955</u>		<u>John H. D.</u>		<u>Le Compte's Funeral Service</u>		<u>Cambridge</u>	



Item 12, Form 189 10-25-55 et

9713

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH

COUNTY Dorchester

MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town)
OR TOWN Cambridge R.F.D.3LENGTH OF STAY
(in this place)
30 yearsHOSPITAL OR
INSTITUTION OR
STREET ADDRESSRural

2. USUAL RESIDENCE (HOME) OF DECEASED.

STATE Maryland COUNTY DorchesterCITY (If outside corporate limits, write RURAL and give nearest town)
OR TOWN Cambridge R.F.D.3

STREET ADDRESS (If rural give location)

Rural3. NAME OF
DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

JosephS.Schaffner

4. DATE (Month)

(Day)

(Year)

OF DEATH.

Oct. 12, 195519

5 SEX:

Male

6. COLOR OR RACE:

White7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)Widowed

8. DATE OF BIRTH:

Apr. 13, 1862

9. AGE last birthday

93 yrs

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS

Hours

Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired)Retired Coal Dealer10B. KIND OF BUSINESS
OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Germany12. CITIZEN OF WHAT
COUNTRY?U.S.A.

13. FATHER'S NAME:

John Schaffner

14. MOTHER'S MAIDEN NAME:

Unknown15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.)no(If Yes, give war or dates
of service)no

16. SOCIAL SECURITY NO.

none

17. INFORMANT & ADDRESS:

Frank L. Schaffner, Cambridge R.F.D.3

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153X

IMMEDIATE CAUSE

(A)

DUE TO

Starvation

ANTECEDENT CAUSE (B):

(B)

DUE TO

Intestinal ObstructionDISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

(C)

DUE TO

Carcinoma of the ColonII OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.Arterio-sclerosis generalisata

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐NO ☒21A. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)
INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

M.

21E. INJURY OCCURRED
While ☐ Not while ☐
at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1953, to Oct 12, 1955, that I last saw the deceasedalive on Oct 12, 1955, and that death occurred at 12.10 P. from the causes and on the date stated above.

SIGNATURE

James L. Thompson

ADDRESS

M.D. Cambridge, Md. Oct 13, 1955

DATE SIGNED/

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

BurialOct. 14, 1955East New Market Cemetery, East New Market, Md.DATE REC'D BY LOCAL
REGISTRAR

REGISTRAR'S SIGNATURE

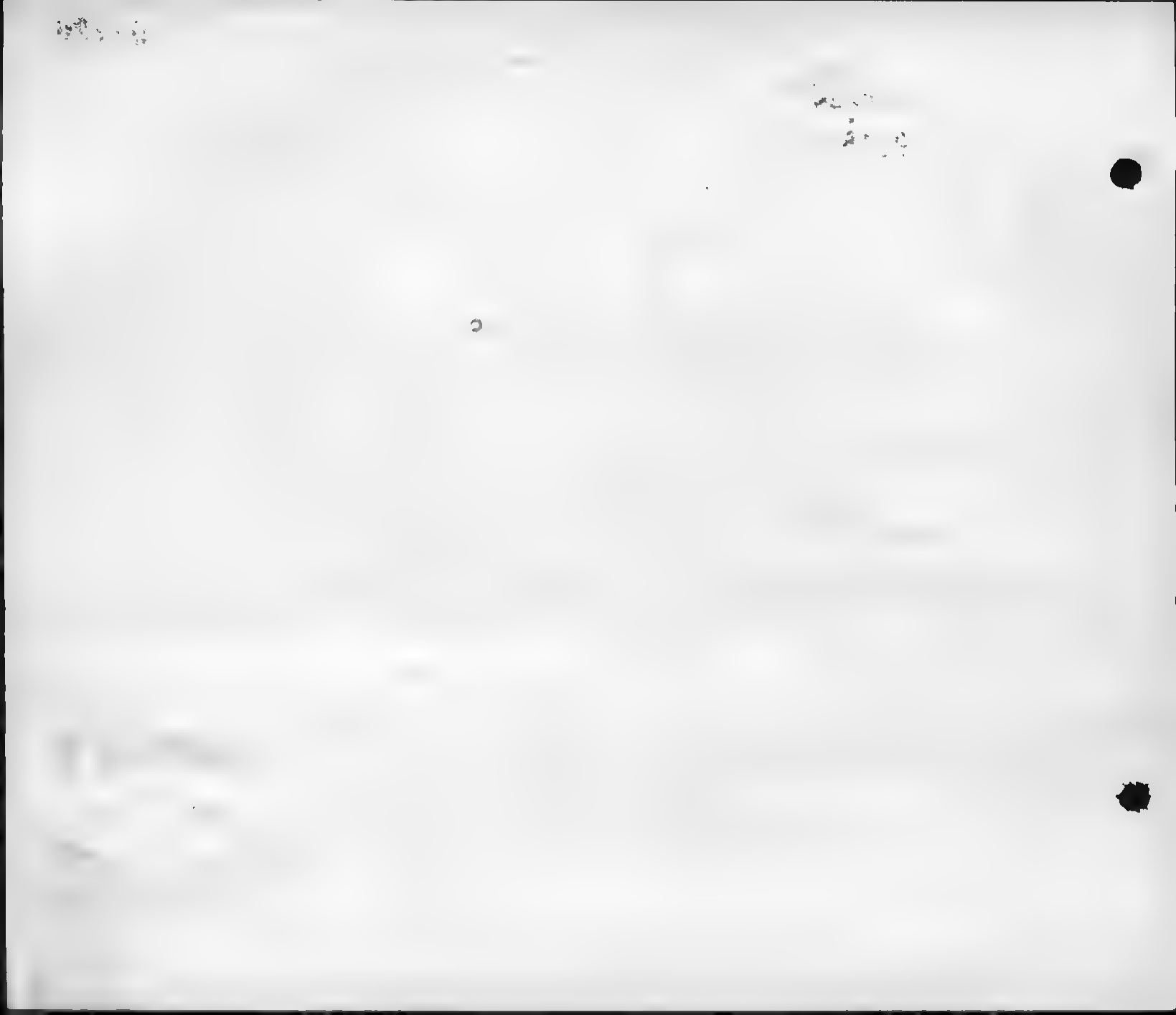
Oct. 14, 1955John Hall, Jr. M.D.

24. FUNERAL DIRECTOR

ADDRESS

Kenneth R. Thomas, Cambridge, Md.

MARGIN RESERVED FOR BINDING



9714

CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED.			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Hurlock - Rural</u>		<u>Life</u>		OR TOWN <u>Hurlock - Rural</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bobtown</u>				STREET ADDRESS (If rural give location) <u>Bobtown</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Ephriam Smith</u>				OF DEATH: <u>October 2, 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>Colored</u>	<u>Widowed</u>	<u>About 1876</u>	<u>About 79</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Day Laborer</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Farm</u>		11. BIRTHPLACE (State or foreign country): <u>Dorchester Co., Maryland</u>	
13. FATHER'S NAME: <u>Henry Smith</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				14. MOTHER'S MAIDEN NAME: <u>Rebecca (maiden name unknown)</u>			
16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT & ADDRESS: <u>Delsia Holliday, Hurlock, Md., R.F.D.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Chronic Myocardial Infarction</u>						<u>56 hr.</u>	
ANTECEDENT CAUSE (B) <u>Arteriosclerosis</u>						<u>5 yr. 2 mo.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Diabetes Mellitus</u>						<u>10 yr.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1950</u> to <u>Oct 2, 1955</u> that I last saw the deceased alive on <u>October 1, 1955</u> , and that death occurred at <u>3:30</u> M, from the causes and on the date stated above.							
SIGNATURE <u>W. C. Smith</u>				ADDRESS <u>Hurlock Md</u>		DATE SIGNED <u>10/2/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Oct. 6, 1955</u>		<u>Washington Cemetery</u>		<u>Near Hurlock, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Oct. 6 - 1955</u>		<u>Charles W. Hastings</u>		<u>J.J. Frampton and Son</u>		<u>Federalsburg, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

44000

44000

100

9715

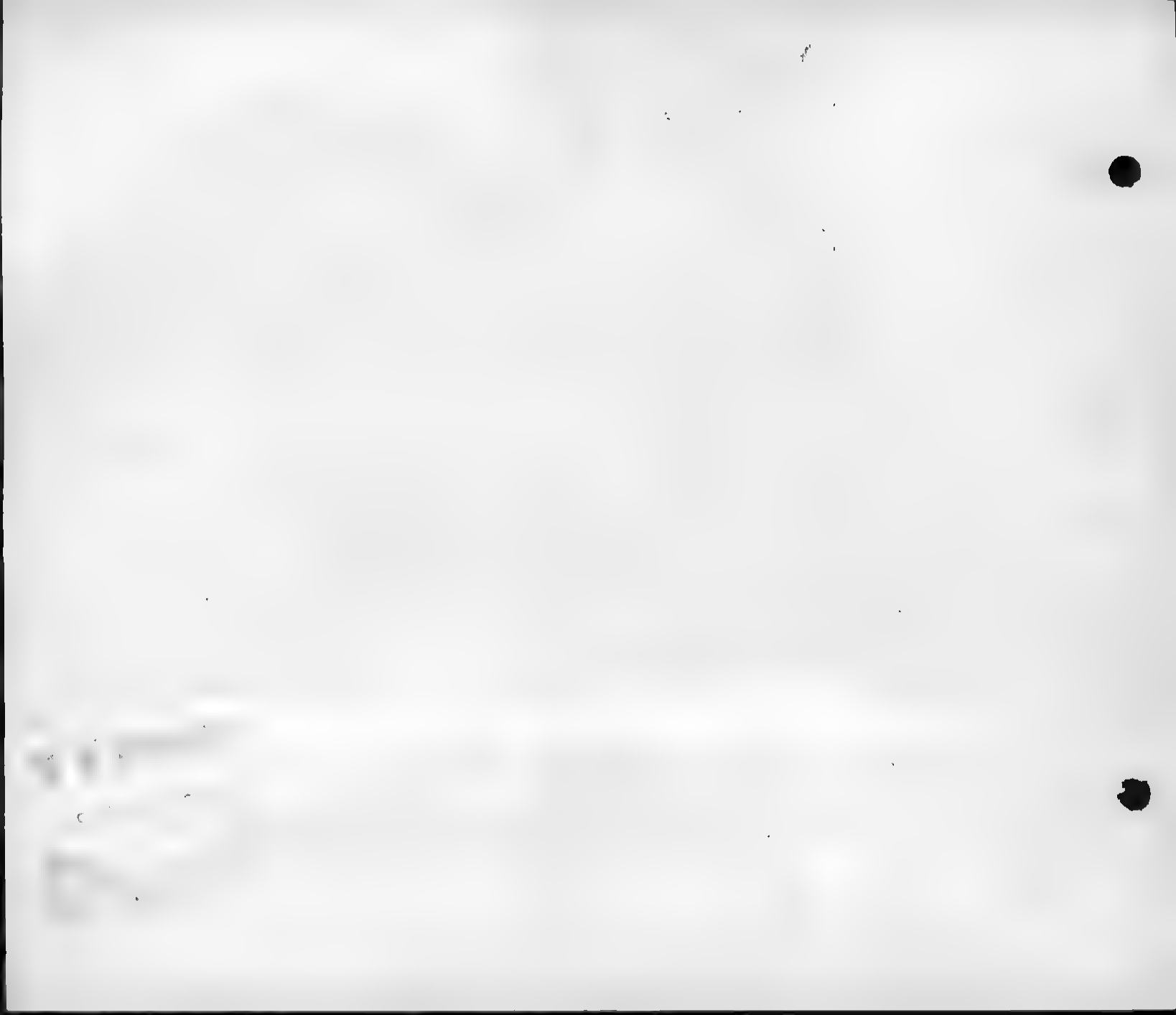
CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X <u>Federalsburg - Rural</u>		<u>Life</u>		<u>Federalsburg - Rural</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eldorado Road</u>				STREET ADDRESS (If rural give location) <u>Eldorado Road</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) (Middle) (Last)				OF DEATH: <u>October 6 1955</u>			
5. SEX <u>Male</u>				6. COLOR OR RACE: <u>White</u>			
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>				8. DATE OF BIRTH: <u>Nov. 14, 1897</u>			
9. AGE last birthday <u>57</u> yrs				10. AGE last birthday IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Day Laborer</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Farm</u>			
11. BIRTHPLACE (State or foreign country): <u>Dorchester Co., Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME: <u>Henry C. Speorl</u>				14. MOTHER'S MAIDEN NAME: <u>R. Matilda Figgs</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-09-8503</u>			
17. INFORMANT & ADDRESS: <u>Mrs. Ralph J. Trice, Federalsburg, Md.</u>							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE							
(A) DUE TO <u>Coronary Thrombosis</u>							
ANTECEDENT CAUSE (S):							
(B) DUE TO <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc.			
21C. WHERE DID (City or town) (County) (State)				21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1927</u> , 19 , to <u>10-4</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10-4</u> , 19 <u>55</u> , and that death occurred at <u>1 A. M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. E. Harrison</u>				DATE SIGNED <u>Oct 10-6-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>Oct. 9, 1955</u>			
NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>				LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>			
DATE REC'D BY LOCAL REGISTRAR <u>Oct 9-1955</u>				REGISTRAR'S SIGNATURE <u>Chas. H. Hastings</u>			
24. FUNERAL DIRECTOR <u>J.J. Frampton and Son, Federalsburg, Md.</u>				ADDRESS			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the cause of death clearly and legibly.

9702

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

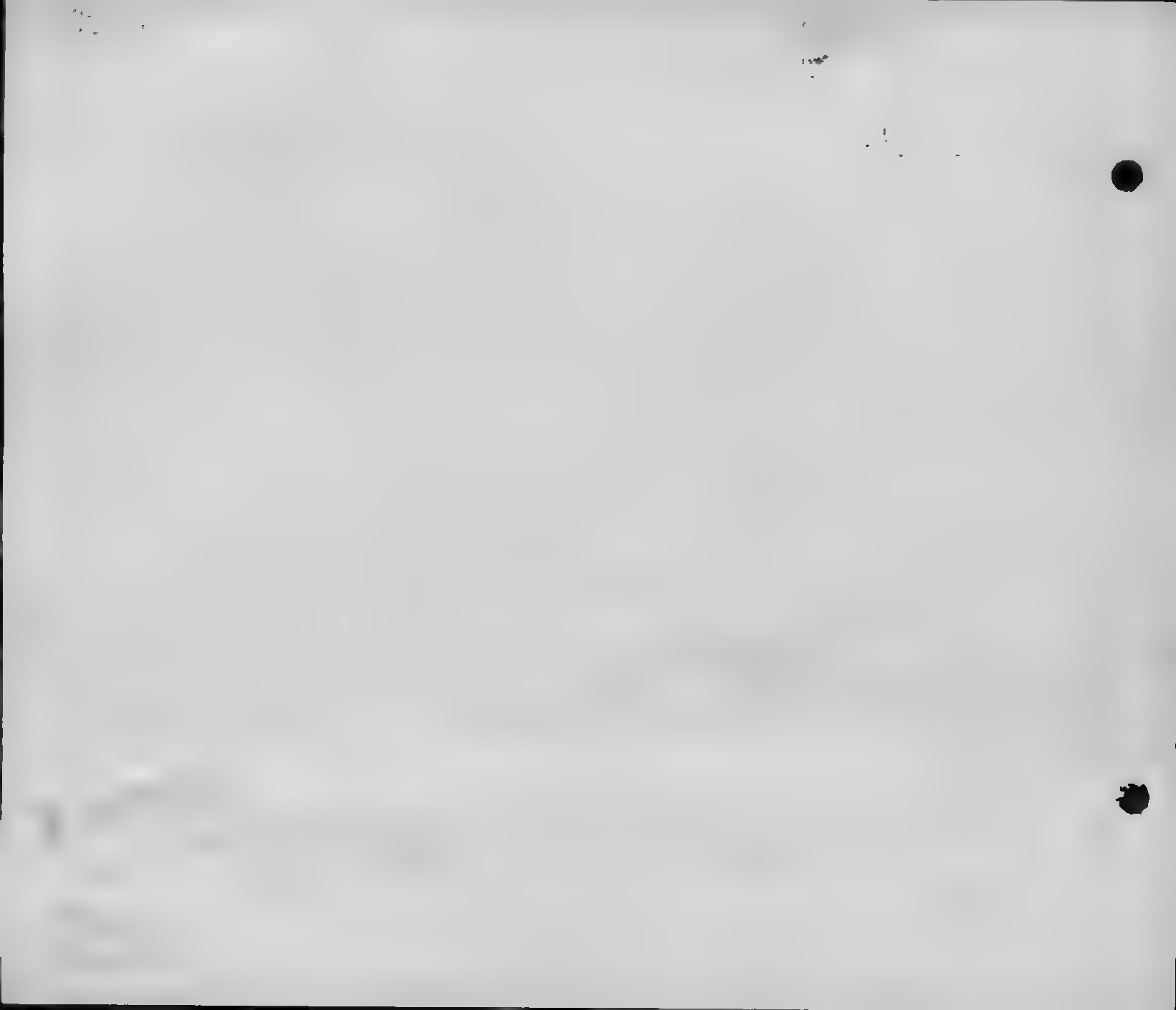
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 114

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Cambridge</u>		<u>X</u>		TOWN <u>Cambridge RFD # 2</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Academy & Muse Sts</u>				STREET ADDRESS (If rural, give location) <u>RFD# 2</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH			
(First) <u>Phillip</u>		(Middle) <u>R</u>		(Last) <u>Stephenson</u>		(Month) <u>Oct</u> (Day) <u>27</u> (Year) <u>19 55</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>7/11/1893</u>		9. AGE last birthday: <u>62</u> yrs.		10. IF UNDER 1 YEAR (Months) <u></u> (Days) <u></u> IF UNDER 24 HRS. (Hours) <u></u> (Min.) <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>US Wild Life</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Fish Culturalist</u>		11. BIRTHPLACE (State or foreign country): <u>Scranton, PA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Eli Stephenson</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Binkley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Mrs Isabelle Stephenson</u>		<u>Cambridge RFD #2</u>	
(If Yes, give war or dates of service) <u>World War I</u>							

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>Immediate cause</u> (a) <u>Coronary occlusion</u> DUE TO <u>Antecedent cause(s)</u> (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town)		(County)	
						(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>. SIGNATURE <u>[Signature]</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Oct. 31, 1955</u> M. D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/30/55</u>		<u>Dorchester Memorial PK</u>		<u>Cambridge Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Oct - 30, 1955</u>		<u>[Signature]</u>		<u>Le Compte Funeral Service</u>		<u>Cambridge,</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09724

9703

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED.			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>13</u> TOWN <u>Cambridge</u>		<u>50 yrs</u>		<u>13</u> TOWN <u>Cambridge,</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>00</u> <u>403 Acadmey St</u>				<u>403 Acadmey</u>			
3. NAME OF DECEASED. (Type or Print)				4. DATE OF DEATH: (Month) (Day) (Year)			
(First) (Middle) (Last)				OF DEATH: <u>10</u> <u>25</u> <u>19 55</u>			
<u>Charles B Todd</u>							
5. SEX	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M</u>	<u>W</u>	<u>Married</u>	<u>July 25 1889</u>	<u>66</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired).		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>retired</u>		<u>Waterman</u>		<u>Crochern</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>William Todd</u>				<u>Melivena Bramble</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>unk</u>		<u>214-20-0860</u>		<u>Mr Insley Todd Cambridge</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE						<u>11 months</u>	
(A) <u>Carcinoma of larynx</u>							
ANTECEDENT CAUSE (B):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>May 20 1955</u>				<u>Carcinoma larynx</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
<input type="checkbox"/>							
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/20/54</u> to <u>10/25</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>10/25</u> , 19 <u>54</u> , and that death occurred at <u>5:30 A</u> M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>[Signature]</u>		<u>M D Cambridge Md</u>		<u>10/25/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>10/27/55</u>		<u>Dorchester Memorial Pk</u>		<u>Cambridge, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Oct 22 1955</u>		<u>John Hagg, Jr. D.</u>		<u>Le Compte Funeral Service</u>		<u>Cambridge</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9716				MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18		09725 Dist.	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 116							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY		Dorchester		STATE		Maryland	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		TOWN		CITY (If outside corporate limits write RURAL and give nearest town)		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Choptank River		STREET ADDRESS		107 Willis Street	
3. NAME OF DECEASED:		(First) Dorothy		(Middle) Burton		(Last) Todd	
4. DATE OF DEATH		(Month) Oct.		(Day) 16,		(Year) 1955	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Female		White		Married		Jan. 25, 1912	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday:		43	
Housewife				Yrs.			
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Golden Hill, Md.		U.S.		Months		Days	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
John S. Burton				Gertrude Fuark			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:	
No		No		220-10-6182		Camp Pendleton, California	
						Sgt. Ronald E. Todd, U.S.M.C.	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) ... Accidental drowning						Instant	
DUE TO							
Antecedent cause(s) (b) ...							
Diseases or conditions, if any, giving rise to the above cause							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.)		21c. (City or town)		(County)	
CAUSE OF DEATH		INJURY river		Nr. Cambridge		Dor.	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
10-15-55 ? M.				Fell from boat.			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED	
						10/13/55	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
Burial		Oct. 19, 1955		Dorchester Memorial Park		Cambridge, Md.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Oct. 18, 1955		Kenneth R. Thomas		Kenneth R. Thomas, Cambridge, Md.			

S A I

10.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9717

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09726
Reg. Dist.

No. 116

1. PLACE OF DEATH: COUNTY <u>Dorchester</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Choptank River</u> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Choptank River</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Dorchester</u> CITY (If outside corporate limits write RURAL and give nearest town) <u>Cambridge</u> TOWN STREET ADDRESS (If rural, give location) <u>107 Willis St.</u>																					
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Woodrow</u> <u>Wilson</u> <u>Todd</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 16, 1955</u> <u>19</u>		5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Jan. 8, 1913</u>		9. AGE last birthday: <u>42</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Traveling Salesman for Hardware Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Toddville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME: <u>Charles M. Todd</u>						14. MOTHER'S MAIDEN NAME: <u>Ada Mills</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u> <u>No</u>						16. SOCIAL SECURITY No.: <u>214-07-8365</u>		17. INFORMANT & ADDRESS: <u>Camp Pendleton, California</u> <u>Sgt. Ronald E. Todd, U.S.M.C.</u>					
18. MEDICAL CERTIFICATION																		INTERVAL BETWEEN ONSET AND DEATH							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>850X</u> Immediate cause (a) <u>Accidental drowning</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) DUE TO																									
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.																									
19a. DATE OF OPERATION:						19b. MAJOR FINDING OF OPERATION:						20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>river</u>						21c. (City or town) (County) (State) <u>Nr. Cambridge</u> <u>Dor.</u> <u>Md.</u>													
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>10-15-55</u> <u>?</u> M.						21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>						21f. HOW DID INJURY OCCUR? <u>Fell from boat</u>													
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																									
SIGNATURE <u>[Signature]</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> <u>10/18/55</u>																			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>						DATE THEREOF <u>Oct. 19, 1955</u>						NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>						LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>							
DATE REC'D BY LOCAL REG. <u>Oct. 18, 1955</u>						REGISTRAR'S SIGNATURE <u>[Signature]</u>						24. FUNERAL DIRECTOR <u>Kenneth R. Thomas, Cambridge, Md.</u>						ADDRESS							

BUREAU V. S.

OCT 20 1955

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 116

9734

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Dorchester</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>13</u> TOWN <u>Cambridge</u>	LENGTH OF STAY (in this place) <u>40 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u> <u>13</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>67</u> <u>Cambridge Maryland Hospital</u>		STREET ADDRESS (If rural give location) <u>102 Franklin Street</u> <u>1</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Henrietta Moore Gootee Willey</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>10</u> <u>9</u> <u>1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>10/9/55</u> ✓
9. AGE last birthday <u>81</u> yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>	11. BIRTHPLACE (State or foreign country): <u>Lakesville, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>Henry M. Moore</u>	
14. MOTHER'S MAIDEN NAME: <u>Zora Mc Namara</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, No, or unk.): <u>No</u> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Claude S. Gootee Jr., 102 Franklin St., Cambridge, Md.</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Corruption heart of failure</u>			<u>7 days</u>
ANTECEDENT CAUSE (B) <u>Coronary thrombosis</u>			<u>7 days</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Anticoagulant given</u>			<u>?</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Uremia</u>			<u>7 days</u>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
22. I hereby certify that I attended the deceased from <u>Aug 9, 1955</u> , to <u>Oct 9, 1955</u> , that I last saw the deceased alive on <u>Oct 9, 1955</u> , and that death occurred at <u>11:00 P</u> M, from the causes and on the date stated above.			
SIGNATURE <u>James W. Thompson</u>		ADDRESS <u>Cambridge, Md.</u>	
DATE SIGNED <u>Oct 10 '55</u>		M. D.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10/12/55.</u>	
NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetary</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Oct. 12, 1955</u>		REGISTRAR'S SIGNATURE <u>John Hall, R. D.</u>	
24. FUNERAL DIRECTOR <u>Le Compte Funeral Service, Cambridge, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 2

OCT 14 1955

RECEIVED